For services provided under the Ryan White CARE Act and other federal/state funded programs

Developed by the Case Management Working Group of the Planning and Evaluation Committee

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INLAND EMPIRE HIV PLANNING COUNCIL
351 North Mountain View Avenue, San Bernardino, CA 92415-0010
Office Telephone # (909) 387-6653 Facsimile # (909) 387-6889

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Letter of Concurrence

We the undersigned are in agreement with the overall content of the client-centered comprehensive case management standards. We do hereby attest that there was significant community involvement in the development of these standards. Further, we pledge our continued support for achieving client/patient autonomy, assistance, and wellness through communication, linkage, education, identification of realistic service resources, efficient and appropriate facilitation of service access, and client advocacy within the Riverside/San Bernardino, California Eligible Metropolitan Area.

Thomas J Prendergast, Jr, MD, MPH
Director of Public Health
San Bernardino County
Community Co-Chair, IEHPC

Phil Sladick
Community Co-Chair
Inland Empire HIV Planning Council

Gary M Feldman, MD
Director of Public Health
Riverside County

Leann Chamlee, Chair
Case Management Standards Committee
Inland Empire HIV Planning Council

Inland Empire HIV Planning Council

Joe Acosta
Sandra Bibb
John L. Brown
Victoria D. Jauregui Burns
Jeffrey A. Byers
Leann Chamlee*
Danny Colon
Ed Cueto*
Faith Davis-Bolton
Darlene Debayona
Steven A. English
Gary Feldman, MD
Fred Flotho*
Gregory French
David Fyffe
Carolyn Harris*
Cherry Houston, Ph.D.
A. Lloyd Jones*
Steven Glenn McGrew
Tom Palumbo
Thomas J. Prendergast, Jr., MD, Co-Chair
Benita Ramsey
Joseph P. Revetto, Ph.D.
Henry (Hank) Simmons
Philip C. Sladick, Co-Chair*
Joshua Sparks
James J. Taylor
Evelyn Valentino
Rebecca B. Zeidler
Edwin Zelaya

**Case Management Working Group Member*

Other Case Management Working Group Members [1]

Connie Aguilar
Jeff Arender
Marie France Francois
Gemma Gonzales
Cindy Monfort
Jerry Nevarez
Joshua Olagunju, Ph.D.
James Olguin
Mark Peppler
Linda Salas
Alexander F. Taylor, MPH
Kathleen Taylor

[1] *With Technical Assistance by John Snow, Inc.:*

Lawrence C Shulman, ACSW, CSW - Consultant
Sociomedical Resource Associates
181 Post Road West
Westport, CT 06880

Riverside/San Bernardino, California EMA
Case Management Standards

MISSION STATEMENT

The Inland Empire HIV Planning Council has defined case management as a system for achieving client/patient autonomy, assistance, and wellness through communication, client collaboration, linkage, education, identification of realistic service resources, facilitation of access to appropriate services, and advocacy.

This Eligible Metropolitan Area (EMA)-wide case management system supports the premise that each individual is empowered with the right to seek the optimum health and social outcome possible in a manner which recognizes his/her dignity, worth, and human rights.

The case management standards for the Riverside/San Bernardino, California EMA will provide rules for quality professional practice and define procedures for the evaluation of practice through consistently defined terms and quality standards that define outcome accountability to government funders, the public, and consumers of service.

The development of case management standards is the result of the collaborative vision and efforts of consumers of service, service providers, public health officials, and other community members. The core elements of the system are embodied in these case management standards. A common goal was to develop a continuum of high quality care that is client centered, client collaborative, culturally appropriate, cost effective, efficient, and accessible to all eligible persons with HIV/AIDS and families throughout the EMA.

Riverside/San Bernardino, California EMA
Case Management Standards

INTRODUCTION

The agencies offering HIV/AIDS Case Management in Riverside and San Bernardino counties provide a multi-level range of services to HIV-infected and high risk persons throughout the EMA, to assist them in accessing medical care, social services or other needed services. The broad goals of the case management system are to:

- # Provide access to services which increase independence and self-sufficient functioning;
- # Provide access to services which prevent or delay hospitalization;
- # Increase access to HIV information, counseling, testing and services;
- # Monitor clients to ensure access to medical and social services in order to promote early intervention;
- # Assure continuity of care and follow-up of clients;
- # Promote coordination among service providers and other support systems to eliminate duplication and foster inter-agency collaboration opportunities;
- # Increase access to appropriate services for, and promote the optimum physical and social functioning of the individual/family.

Towards these goals, the Inland Empire HIV Planning Council has established these standards of case management which help to ensure that services: a) are accessible to all persons infected and affected with HIV, b) achieve a defined high quality of care, c) promote continuity of care throughout the EMA, and d) protect the rights of persons living with HIV disease.

Riverside/San Bernardino, California EMA
Case Management Standards

BENEFITS OF EMA CASE MANAGEMENT

When provided under the standards defined herein, case management will result in the following benefits to clients served:

Educate and Empower
Improve Access to Services
Reduce Barriers and Obstacles
Enhance Quality of Life for Person Living with AIDS
Improve Emotional Wellbeing
Ensure Consistent Primary and Specialty Medical Care
Assure Responsiveness of Care Services
Assist in Access to all Available Community Services
Ensure Social and Concrete Services Support
Reduce Social Isolation
Foster Independence, rather than Dependence
Reduce or Minimize Service Duplication and Cost
Foster On-going Collaboration
Enhance Community Involvement
Expand Service Network
Advocacy Based on Data and Experience

Applicability/Amendment

These standards were developed primarily to be utilized by the grantee(s) of the Ryan White Title I and Title II funding for the EMA, however they are intended to apply to all agencies within the two county area which are publicly funded to provide case management services for individuals living with HIV disease (and their family members, as indicated).

These standards will be amended as needed through a process conducted by the Inland Empire HIV Planning Council, with input from and involvement by the coordinating body (as defined in this document) and appropriate consumer representation.

Definition of Family for the Purposes of This Document

When this document refers to "family," it is intended to include biological family members, partners, significant others, and other individuals upon whom the HIV-infected person significantly relies for support to maintain the quality of his/her life.

Riverside/San Bernardino, California EMA
Case Management Standards

STANDARD: **Applicability of Standards for Case Management**

All agencies in the Riverside/San Bernardino, California EMA which are funded to provide HIV/AIDS case management services shall include an agreed-upon range of activities required to deliver a high quality, comprehensive service to persons living with HIV/AIDS and their families. These minimum requirements were approved by the Inland Empire HIV Planning Council on August 27, 1998.

RATIONALE: HIV/AIDS case management in this EMA model involves the interface of managerial and clinical processes. Its goal is to maximize services, resource availability, effectiveness and cost efficiency, and be appropriate to the client's needs. The medical and social complexity of HIV/AIDS and the episodic and chronic nature of associated illnesses necessitates differing services and continuous coordinating efforts among multiple providers. Case management is interactive and specific to the level of need. Case management:

assesses, plans, coordinates, monitors, and advocates for necessary services
is client/family centered and collaborative
involves client/family/staff shared responsibility
promotes the independence and empowerment of persons living with HIV/AIDS
links the client to core, ancillary, and access services (as defined in the EMA's comprehensive services plan)
identifies alternative ways of coping with limited resources
seeks to assure continuity of care
is goal and outcome oriented

DISCUSSION: Case management is a multi-step process which ensures coordination and timely access to a range of appropriate medical and social services. This process includes, at a minimum, the following activities:

Client Orientation
Intake and Screening
Assessment
Initial Individualized Service Plan Development
Individualized Service Plan Implementation
Coordination of Services
Monitoring
Individualized Service Plan/Reassessment and Implementation
Crisis Intervention Activities
Changes in Service Levels
Termination/Case Disposition Activities

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In addition, the following activities are integral components of this EMA's case management system:

- Client Advocacy
- Knowledge of Client Rights
- Interagency Coordination
- Identification of Service Gaps
- Systems Development Activities
- Supervisory Review/Case Conferences
- Staff Education and Support

Each community service agency must develop objectives in line with its mission, purpose and local conditions. The case management system in the Riverside/San Bernardino, California EMA seeks to reduce high risk behavior, provide or obtain health and mental health care, minimize the need for hospitalization, provide or obtain psychosocial or other support services and involve family members when appropriate. Shared objectives common to all case management providers in the EMA are:

- Identification of clients
- Engagement of, and collaboration with, clients
- Completion of screening, intake and assessments
- Completion of individualized service plan (as required by these standards)
- Provision of necessary counseling on health and social issues, and HIV/AIDS prevention and treatment
- Linkage of clients with one or more services or agencies, if necessary
- Support for clients' follow through and continuation of services
- Monitoring of clients to determine whether they continue to utilize services
- Maintenance of records on each client for evaluation of case management effectiveness
- Maintenance of records of unmet needs to be used in advocacy efforts

Riverside/San Bernardino, California EMA
Case Management Standards

STANDARD: Type of Case Management System

The Riverside/San Bernardino, California EMA will utilize a multiple agency approach to providing case management services for persons living with HIV/AIDS and their families. The Inland Empire HIV Planning Council has directed the development of standards of case management service delivery to ensure non-discriminatory comparable access, scope, quantity and quality of service for each person living with HIV infection within the EMA to the degree possible based on geographic barriers.

RATIONALE: The choice of this approach recognized: 1) the vast geographic service area of the Riverside/San Bernardino, California EMA and the concomitant access issues; 2) the fact that client needs differ significantly throughout the EMA and that local communities need to have maximum input in case management system design; 3) a belief that client choice and self determination should be key considerations; and 4) the unanimous belief that a system built on collaboration, cooperation and utilization of the resource strengths of each agency will enable the provision of the most effective services to persons living with HIV/AIDS.

DISCUSSION: Success of the multiple agency approach to developing a case management system for the EMA will depend on commitments at the EMA level, provider level, and client level, and will be influenced by various administrative considerations:

EMA Level

A standardized system to identify levels of case management service need will be implemented EMA-wide by all providers of case management services.

Definitions of the specific scope of case management service delivery will be developed for each level of service (staging). Key elements will minimally include: an analysis of available services; level of professional preparation required of staff; training and supervision; staffing ratios; client rights; client monitoring/follow up, and documentation.

A coordinating body comprised of representation from each case management funded entity, the respective public health department, and persons living with HIV/AIDS will monitor the appropriateness and effectiveness of case management services delivered both at the EMA and specific provider service level. Functions of the coordinating body will be:

(continued)

- < Development and implementation of uniform program monitoring and evaluation tools both at the EMA and provider service levels. Key components would include: quality assurance standards and indicators, utilization review, client satisfaction, grievance procedures;
- < Oversight of interagency agreements for sharing or transfer of care within the framework of client choice; this oversight will determine the scope of service capability with the intent to minimize duplication;
- < Ongoing problem solving of system issues which are a barrier to the effective delivery of case management services in the EMA, including the identification of gaps in the continuum of care;
- < Development of guidelines for standard client records for transfer between providers, along with standard intake and data formats;
- < Development of mandatory minimum requirements versus recommended procedures;
- < Secure or provide training for all staff responsible for case management services.

Provider Level

- # Provider agencies will participate in the interagency coordinating body;
- # Each provider agency will develop a list of clearly identified services and the scope of those services they offer;
- # HIV service agencies will develop interagency agreements for referral and collaboration;
- # Agencies that do not provide comprehensive case management will develop a referral plan and service agreements with capable providers;
- # Agencies will provide "duty to warn" (i.e., legally mandated procedures) and "public health issues" (i.e., communicable diseases, secondary prevention) training to all staff, as part of the training required for all levels of service;
- # Multiple service providers may be referred to within the context of an individualized service plan (ISP); however, only one agency shall assume responsibility as the primary case management provider for a single client/family.

Client Level

- # As the consumer, clients have the freedom of choice of providers and the right to switch to a new provider; however, only one primary HIV provider (i.e., agency) of case management services may be used at a time;
- # Clients will provide feedback to providers regarding satisfaction with services via quality assurance surveys, case termination discussions and grievance procedures;
- # Clients/consumers will participate in the coordinating body in decision-making roles;
- # Clients are expected (to the degree that they are able) to be active participants in, and take responsibility for, their own self-care.

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Riverside/San Bernardino, California EMA
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Administrative Considerations

The standards developed by the Inland Empire HIV Planning Council are intended to be referenced in the request for proposals (RFP) or other procurement process utilized by administrative entities granting case management funds. In the application process, entities must document their agreement to abide by these standards, or explain why specific requirements cannot be met (the grantee is empowered to determine if waivers from specific requirements can be granted). The granting agencies will be encouraged to consult with the coordinating body in the design of evaluation tools for contract compliance review. Funded providers will be instructed in self-evaluation processes, and will be offered technical assistance on assessment tools and formats utilized by the granting agency in its contract monitoring.

It remains a priority of the EMA to develop and implement an EMA-wide client data information system. This system will support one of the core principals of these standards: that a single individual can be tracked through multiple service sites, with funded primary case management being coordinated by a single provider.

Given the complexity of the technical challenges, however, this process will be undertaken by the EMA according to its own achievable time frame. The implementation of these EMA-wide case management standards will not be contingent on the completion of this task.

CORE CASE MANAGEMENT ACTIVITIES

Client Orientation: The process (provided in an individual or group setting) of providing client orientation activities regarding agency services prior to intake/assessment, during screening/intake or upon completion of screening and intake. Orientation to include outline of clients' rights and responsibilities.

Intake/Screening: The process of information gathering regarding: demographics, disease process, health history; medical, psychosocial, substance use/abuse history; financial management capabilities; income; medical and dental health insurance coverage; long term/short term benefits needed/available; available support systems; employment history, and other met or unmet needs. This activity also includes the process for determining eligibility for enrollment in the case management program, including assessment of "crisis-level" need and determination of service utilization among multiple providers.

Assessment: The assessment of the person's situation and functioning abilities, to identify individual needs (based on intake information and criteria), inclusive of the assessment of the person's awareness or perceived need of the HIV/AIDS disease spectrum, safe/safer sex activities, HIV/AIDS treatment modalities, medication adherence, wellness options, and proper nutrition.

Referral: Based on intake information and assessment outcomes, referrals to in-house programs and/or community resources (inclusive of private and/or governmental services) can be made. A client may be placed on the roster for intermittent telephone follow-up, referral to inactive status, or regular contact with a Level I, II, or III case manager.

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Planning: The process that determines specific objectives, goals, and actions designed to meet the client's needs as identified through the intake and assessment process. The individualized service plan (ISP) must be action-oriented, time specific, appropriate to the level of case management service, and involve the active participation and collaboration of the client.

Implementation: The process of executing specific case management activities or interventions that will lead to accomplishing the goals set forth in the ISP.

Coordination: The process of identifying, securing, and tailoring the resources necessary to accomplish the goals set forth in the ISP.

Monitoring: The on-going process of gathering sufficient information from all relevant sources about the implementation and appropriateness of the ISP and its resulting activities to enable the case manager to determine the service plan's effectiveness.

Reassessment: The process, repeated at appropriate intervals as defined in these standards, of determining the ISP's effectiveness in enabling achievement of desired goals and outcomes. This may lead to a modification or change in the ISP, in its entirety or in any of its component parts.

CORE CASE MANAGEMENT COMPONENTS

1. **Client Education**
2. **Coordination and Service Delivery**
3. **Understanding of Physical and Psychological Factors**
4. **Understanding of Benefits Systems**
5. **Understanding of Case Management Service Concepts and Efficiencies**
6. **Identification of Appropriate Community Resources**
7. **Establish Appropriate Service Level (see pages 12-a to 12-f)**
8. **Continued Re-Assessment of Service Levels**

All of the above components must:

- # Be applied across a continuum of care that addresses the on-going needs of the individual being served by the case management system, across all activities: intake, screening, assessment, referral, planning, implementation, coordination, monitoring, and reassessment; and
- # Be applied in the client's current environment. These environments would include home, workplace, hospital, ambulatory facility, special facility, or community agency; and
- # Involve interactions with all relevant (and agreed upon with client) components of the client's health care system (depending on level), such as physicians, family members, second/third-party payers, employers, and other health care providers; and
- # Address with the individual's and family's broad spectrum of need.

Acuity Scale: See following pages 12-a to 12-f

CASE MANAGEMENT SERVICE COMPONENTS

Entry Into System
❖ Screening and intake I, II, and III ❖ Assessment I, II, and III ❖ As needed, client advocacy, information, and referral ❖ Referral to appropriate level of need to level I, II, or III case management

Level I
❖ Client orientation ❖ Screening and intake ❖ On-going case management monitoring ❖ Level I – additional assessment ❖ Individualized service plan ❖ Contact minimally every six months

Level Ie
❖ After the initial acuity screening or during subsequent reassessments, the client and case manager may mutually agree to have a Level I client who indicates they have no current service needs categorized as a Level Ie acuity. Client contact will be once every twelve months by the case manager. The client may continue to access other services (food, transportation, support groups) as needed.

Level II and III	
❖ Client orientation ❖ Screening and intake ❖ On-going comprehensive case management ❖ On-going crisis intervention when required ❖ Additional assessment as necessary ❖ Individualized service plan (ISP) ❖ Level II contact minimally every three months ❖ Level III face/face contact every two months, phone contact every month	
Development of Individualized Service Plan (ISP)	❖ Determine specific objectives, goals, and actions designed to meet the needs ❖ Service plan must be time specific
Initial Service Plan Implementation	❖ Executes specific case management activities and/or interventions that will lead to achieving goals stated in the service plan
Coordination of Services	❖ Organize, secure, integrate, modify resources necessary to accomplish goals stated in the service plan
Monitoring	❖ On-going process of gathering information from all relevant sources that relate to the case management service plan and its activities and/or services to enable case manager to determine the service plan's effectiveness
Reassessment	❖ Process, repeated at appropriate intervals, of determining the service plan's effectiveness in reaching desired goals and outcomes ❖ May lead to modification/changes to the service plan, in part or in its entirety

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CLIENT PLACEMENT

Screening, Intake, Assessment

Provided by: Case Manager or Supervisor

- On-call client advocate for information and referral
- New client intake/screening/assessment - referrals to level I, II, or III case management
- Comprehensive analysis of needs and resources available to meet needs

Case Management Referrals

Provided by: Case Manager or Supervisor to level I, II, or III, depending on severity of need (medical, psychological and/or social)

LEVELS OF CASE MANAGEMENT SERVICES

Level I – On-going Individual or Team Case Management

Characteristics:

- minimal immunodeficiency; asymptomatic; (CD4 count typically > 500)[1]; low to undetectable extracellular viral RNA
- minor overall health impact of disease
- support system in place

Service needs:

- community referrals given
- education provided
- mailing list placement
- contact minimally every six months
- may be reassessed at later date and referred to another case management level
- intermittent/episodic monitoring to assess progression/ needs/ adherence support
- benefits screening and monitoring
- individualized service plan in place

Client/Case Manager Ratio:
Approx. 120-240 to 1

- volunteer/staff case aide(s) may be utilized for specific tasks under supervision of case manager

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Level II – On-going Individual or Team Case Management

Medical Factors:

- moderate to severe immunodeficiency (CD4 count typically between 201-500)[1]
- medication oversight (as needed)
- may require additional assessment information

Physical Factors:

- intermittent limitations with coordination, mobility, and/or movement
- need for meal preparation one-four times per week (three-twelve meals)
- intermittent personal care, such as bathing or dressing (as needed)
- sight, hearing, or sensory loss (if demonstrated)
- incontinence (if demonstrated)

Psychosocial factors:

- intervention and/or ongoing treatment for alcohol/drug (as needed)
- intervention and/or ongoing treatment for mental health issues (as needed)
- begin to identify anger, grief, loss, depression, and denial as it applies to the disease process
- begin to identify relationships which will require closure
- begin preparation for expanded need of support

Case Management Factors:

- access services/benefits/entitlement eligibility (as needed)
- intermittent transportation assistance (as needed)
- short-term rental/mortgage/utilities assistance to maintain stable housing;
- ongoing assessment, planning, implementation coordination, monitoring, evaluation, and service delivery oversight per the individualized service plan
- contact minimally every 120 days

Client/Case Manager Ratio:
No more than 200 Level I and II clients combined

- volunteer/staff case aide(s) may be utilized for specific tasks under supervision

Level III – On-going Individual or Team Case Management

Medical Factors:

- severe immunodeficiency with life threatening symptoms or requiring comfort care (CD4 count typically less than 200)[1]
- may require additional assessment information
- in-home care with ongoing assistance and assessment
- medication oversight

Physical Factors:

- limitations with coordination, mobility, and/or movement
- need for meal preparation 4-7 times per week (12-21 meals)
- sight, hearing, or sensory loss (if demonstrated)
- incontinence (if demonstrated)
- ongoing personal care, such as bathing or dressing
- skilled nursing care (in-home or facility, as needed)

Psychosocial Factors:

- intervention and/or ongoing treatment for alcohol/drug (as needed)
- intervention or ongoing treatment for mental health issues
- identify care givers
- identify and process anger, grief, loss, depression, and denial
- reach closure in relationships
- mental health diagnosis (chronic or long term issues)

Case Management Factors:

- short-term rental/mortgage/utilities assistance to maintain stable housing;
- intermittent transportation assistance
- access services/benefits/entitlement eligibility (as needed)
- ongoing assessment, planning, implementation coordination, monitoring, evaluation, and service delivery oversight per the individualized service plan
- face-to-face contact minimally every 60 days and telephone contact every 30 days

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Client/Case Manager Ratio:
No more than 70 combined acuity level clients with no more than 20 - 40 of these being Level III clients

- volunteer/staff case aide(s) may be utilized for specific tasks under supervision
- (ratios may be dependent on funding regulations)

[1]CD4 counts are utilized as a base line only to support severity of immunodeficiency as categorized by the 1997 Guide to Primary Care disease (Scott Eberle, MD and Marshall Kubota, MD) and is not definite criterion for case management placement as other medical /psychological impairments may require a higher level of monitoring.

Change In Service

Case Termination

- **May be planned or unplanned**

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Case Management Standards

- **Based on goals, objectives, and outcomes being met/completed**
- **Change may warrant move to a higher or lower level of service**

STANDARD: Case Management Process
A. Client Orientation
Each agency shall provide client orientation activities prior to screening and intake, during screening and intake, or upon completion of screening and intake.

RATIONALE: Client orientation allows the client (and support person, if applicable) to see the agency and understand what the agency does and does not provide. It begins a partnership in personal health responsibility between the agency staff and the new client. Client orientation may be provided on a one-on-one basis or in a group presentation. Orientation shall be designed to provide necessary information, including an outline of clients' rights, and other useful information as outlined below.

DISCUSSION: Client orientation includes the following:

Medical services
Introduction to the agency
Introduction to various program staff
Agency/organizational structure
Funding sources/agency limitations
Program costs
Individual program presentation
Volunteer services
Wellness services
Substance abuse services
Importance of medication adherence
Secondary prevention activities, including safe/safer sex information
Confidentiality (legal and ethical)

Client orientation offers new agency clients the opportunity to ask questions about the agency, programs, medical care, etc., as well as to see and meet staff in a relaxed orientation format. Client orientation encourages a partnership with emphasis on a team concept of health care.

If client orientation occurs prior to initial screening and intake, the new client(s) will be given all intake materials and resource listings, as well as an appointment for their initial screening and assessment appointment.

New clients who are unable to attend client orientation due to significant disease progression, will receive the above information at an appropriate time by their specified case managers.

STANDARD: Case Management Process
B. Screening and Intake

Each agency shall establish a mechanism for the prompt and timely screening of applicants for case management services. The agency shall develop a timely, appropriate and efficient system for data collection during the intake process. Provision shall be made for handling emergency requests from a client or a referring agency. Written collaborative agreements for client reassignment shall be developed to minimize duplication of data collection, and ease the burden on applicants. Clients shall be informed at this stage of the policy in this EMA requiring one single primary case management agency for each client.

RATIONALE: Screening determines eligibility for enrollment in the program. Intake is the collection of identifying information concerning the client, family, caregivers, formal and informal supports. Together, they provide the basis for initiating case management activities, completing a comprehensive assessment, and determining the receipt of services from other providers. Client identification may result from outreach efforts, referrals from various sources and through self-referral.

DISCUSSION: An eligibility screening process must be completed in a timely manner. Screening and intake procedures must be completed within ten working days of the individual's referral to the provider or completion of client orientation. Intake procedures will be performed by the case manager or supervisor. Intake information must be documented in a format developed or approved for the EMA. All efforts must be made to process incoming potential level III clients quickly, by providing eligibility screening within 48 hours (or two working days) of initial request for service; following this, intake procedures will be completed within five working days.

Information to be collected for screening and intake includes:

the referral source and date of referral or first contact;
identifying and demographic information;
HIV diagnosis;
a list of family members and co-residents;
identification of the primary caregiver and legal guardian(s) of children not currently living at home;
client's specific confidentiality concerns;
pertinent medical information, housing status, financial status and other issues requiring immediate attention for the client;
emergency contact(s);
health insurance(s);
languages spoken; and
the date intake is completed.

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Emergency (immediate) needs identified through the intake process should be addressed by the case manager and appropriate services should be implemented promptly.

The intake process also includes obtaining client consent to case management services and may involve home visitation (depending on service level), and inter-agency case conference. The consent form for case management must include confirmation that the case management program has been fully explained to the client, including the client's right to choose care providers (when available), and that they have chosen to enroll in the agency program. A copy of the client handbook, including "client rights," must be given to the client at intake.

The Inland Empire HIV Planning Council will develop additional case management documentation guidelines and forms that will be adopted and must be implemented by all funded agencies.

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Case Management Standards

(Insert Screening/Intake forms here)

STANDARD: Case Management Process
C. Assessment

Each client accepted through the intake process shall receive a comprehensive assessment of need(s) and resources (personal, agency, community) available to meet those needs. Assessment is the process relating to the collection, analysis and professional evaluation of information about the client's history and current medical, physical and psychosocial condition(s), resources, deficits and needs. This process may take one or more interviews, with comprehensiveness being dependent upon service level placement (refer to case management service levels).

RATIONALE: The purpose of an assessment is to identify and measure the client's/family's problems and service needs for the purpose of service planning (i.e., what service needs are being met and by whom; what services have not been accessed or are not adequately coordinated) as well as to evaluate the strengths/resources of the client and support system. The assessment is the basis for determining the level of service that is appropriate.

DISCUSSION: Assessment activities must be completed no later than ten working days from the date of the completed Intake. Completion of the assessment is the primary responsibility of the case manager, who may be assisted by or other designated and qualified staff.

The assessment process must be conducted during one or more face-to-face interviews and may include a home visit (depending on service level) to evaluate the client's medical and psychosocial needs, informal supports, and general living conditions (if applicable). The assessment must include a description of the individual/family functioning as a unit; identification of psychosocial, medical, financial and other problems affecting the client/family; and must include dissemination of information about preventing the transmission of HIV and secondary exposure.

The initial assessment must focus on immediate health and social services needs and address the client's history and pattern of utilization of care. The following information will be included in the assessment:

past or present health status which, depending on service level, may include, but is not limited to, tuberculosis (TB), sexually transmitted diseases (STDs), gynecologic matters, disease progression, medications, other known medical conditions;
activities of daily living, functional status;
alcohol/drug use history;
mental health issues;

(continued)

- nutrition;
- dental needs;
- employment/education;
- financial resources, entitlements;
- housing;
- transportation;
- support systems;
- parenting/children's needs/child care;
- legal (e.g., health care proxy, guardianship arrangements);
- spiritual needs
- adherence support for medication protocols
- knowledge of secondary prevention

Other service providers must also be contacted (with written client consent) to gain additional perspectives if such perspectives are necessary to complete client assessment.

To discuss an individual's case with another provider, agencies must first secure the client's documented permission to release necessary information to that agency. The release form must be consistent with currently applicable regulations regarding release of information.

Upon completion of the process, each assessment will be recorded on a form developed by the agency (or on common forms adopted by the EMA) and shall contain case manager signature and date of completion, along with supervisory signature and date, signifying review and approval.

STANDARD: Case Management Process
D. Individualized Service Plan (ISP)

An individualized service plan (ISP) is a case management and care coordination plan based on the comprehensive assessment, and shall be developed in collaboration with the client (and others involved at request of client) to reflect needs, lifestyle and appropriate priorities for implementation.

RATIONALE: Development of the ISP requires the translation of assessment information into specific achievable goals and objectives, with defined activities, services, providers and time frames to reach each objective. The ISP includes defined actions to be undertaken by client/family as well as the case management provider.

DISCUSSION: The initial individualized service plan must be completed within 15 working days of the date of intake. The case manager has primary responsibility for the development of the service plan, with assistance from team members and in conjunction with the client, family representatives and other providers. A copy of the ISP shall be provided to the client.

Assessment information is used to guide the identification of short term and long term goals. These goals, and resultant activities and services, are determined with participation of the client and support persons. Ideally, professionals from relevant disciplines and agencies are also involved in the development of the service plan and will have agreed to assume specific functions/responsibilities. Actions to be taken by the client, case manager, and others, including family members should be clearly defined. Two important aspects of the plan are the client's personal and capacity-building goals. The plan must clearly identify the primary case manager assigned to the client, with a signature indicating client agreement. The process for changes of assignment of primary case manager (agency initiated or client initiated) shall be clearly explained to the client.

The ISP will reflect services to be accessed on behalf of the client/family and identify expected outcomes. If services actually provided differ from the plan, the case record must contain a note explaining the modification. Goals for family members/other support persons must be clearly identified as such. A copy of the plan must be given to the client. The ISP includes:

goal(s);
activities (actions to be taken), including counseling and education, and adherence support;
agency which, or individual who, will perform the activity (e.g., case manager, client, family member, agency representative);
anticipated time frame for completion of goals (weeks, months, a year or more);
expected outcomes;
case manager signature and date, signifying implementation.

STANDARD: Case Management Process
E. Individualized Service Plan Implementation

Implementation of the individual service plan (ISP) shall begin immediately after the plan is agreed upon by agency and client/family. This process shall involve the case manager and client in referrals to other health and social services and entitlement programs, and will use appropriate counseling and service coordination activities.

RATIONALE: Case management provided under these standards should encompass a fully integrated approach. The primary (or designated) case manager coordinates all necessary services (institutional and community based), along the continuum of care, by directly arranging access to services or by establishing linkages with other public, not-for-profit or proprietary service programs. The role of the case manager is to reduce service, agency and administrative barriers to ensure that clients obtain needed services. The primary case manager will coordinate services through on-going contacts with other service providers/case managers who may also serve the client, as well as the client's support system. Services accessed for the client should include medical and non-medical health services, social and other support services and linkages to existing community resources.

DISCUSSION: Service plan implementation is the ongoing responsibility of the case manager and will begin immediately after service needs are assessed. The case manager and other team members will assist the client/family as needed, in contacting support persons and collaborating agencies to negotiate the delivery of planned services. These contacts include face-to-face (in office or in the home), telephone, and mail. The case manager intervenes as necessary to assure that referrals are completed and that the client receives competent, respectful attention. The service plan may be modified to accommodate the client/family members and service providers. Any changes from the original plan must be noted and explained in the record.

Clients and other members of their support system, consistent with the responsibilities identified in the ISP, should be encouraged to carry out the agreed upon tasks. The case management process must take into consideration client strengths and encourage active client participation in all phases of the plan. It is the responsibility of the case management staff to ensure and/or perform the following activities:

contact providers, including support persons, by telephone, in writing, or in person to determine and articulate the ongoing responsibilities of each provider;
assist the client, family members or support system individuals in making applications for services and entitlement programs, including basic needs such as transportation, housing, child care, food stamps, etc.;

(continued)

- give other service providers accurate and complete information about the service(s) they are expected to provide and the services provided by others;
- obtain assurances from other care providers that services will be initiated, and follow-up to confirm the delivery of these services;
- schedule multiple visits on the same day if reasonable to accommodate the needs of the client/family;
- document services that are not available or cannot be accessed; and
- monitor and assist the client to maintain optimal physical health and psychosocial well-being.

Coordination of services may involve frequent contact with providers and clients to ensure that services have been arranged and received. Guidelines for contact include:

- upon determination of service need, assist client with any necessary applications or forms that need to be completed, if appropriate;
- confirm approval of services to be provided and, if possible, set a timely and appropriate date for service delivery;
- services which are necessary to assure the immediate safety and health of the client/family may require immediate contact and follow-up;
- for life-sustaining services which have been arranged through nursing or other home care referral, case management staff must coordinate with the agency, hospital or health center case managers to confirm receipt of services within 24 hours after agreed upon service delivery date.

Riverside/San Bernardino, California EMA
Case Management Standards

Sample Individual Service Plans: See following pages 25-a to 25-f

STANDARD: Case Management Process
F. Coordination Of Services

Each case manager will coordinate all available services to ensure efficient and effective service planning outcomes.

RATIONALE: In order to implement the individualized service plan in an efficient and effective way, case managers must organize, secure, integrate, and modify throughout the case management process all resources necessary to accomplish goals stated in the plan. Without continuous coordination of services, gaps in services may begin to appear and continuity of care will begin to lapse.

DISCUSSION: Coordination of psychosocial and health care services is an on-going event throughout the case management process. This assures that as the needs of the client changes, the case manager will have the ability to access/refer to additional/new available resources that may be more appropriate for a given client at a particular point in the disease process.

The coordination of services is an integral part of comprehensive service planning and must be continuous so as to assist in the success of the comprehensive case management process. In order to have successful case management service planning, the case manager must organize, secure, integrate, and modify all resources necessary throughout the case management process to effectively accomplish service plan goals.

STANDARD: Case Management Process
G. Monitoring

Each primary case manager shall be responsible for monitoring the activities, progress, intervening problems, barriers evidenced, and goals achieved in order to verify and validate services provided per the individualized service plan (ISP).

RATIONALE: Because circumstances, health status, needs and relationships change during the implementation of the case management process and the access of services, the case manager together with the client/family must constantly review and revise the assessment or ISP. Monitoring is enhanced through contact between the case manager or other team members and the client or representative, support persons and service providers. The purpose of these contacts is to assure that services are being delivered according to the ISP. Contacts may include encounters in the agency, home, hospital or outpatient clinic, and other community providers' office settings. Contacts may occur by telephone, mail or in person. Any problems noted during monitoring contacts will be followed up with the client, support person or provider, as needed, to address the problem. Coordination with other service providers must be evident in progress notes that accompany the plan.

DISCUSSION: For all clients, the case management team, in conjunction with the current medical provider, are responsible for regular tracking of the client's overall need status. This involves case conferences with medical providers for confirmation of a client's HIV status and progression of disease, particularly as part of a reassessment process. TB status, gynecological status, CD4 count and extra-cellular viral RNA (if available), nutrition, medications (including side effects) and other relevant information must be regularly monitored. Appropriate referral sources must be identified through these periodic assessments. When requested, or when high-risk behavior is reported or suspected, prevention education with the client and other family members should also be provided.

Frequency of contacts in all levels of service (I, II, III) must be established by individual case (within minimum times indicated in these standards). In certain difficult and complex cases, contacts may be on a daily basis--especially during times of crisis.

(continued)

The schedules of team members should be flexible enough to allow for intense intervention when it is needed. Conversely, some clients may receive less intensive case management, such as those with whom a case management relationship has been established (and who are experiencing periods of stability), non-compliant clients, and those lost to follow-up.

The ISP must be updated, at a minimum, annually for Level Ie, every 180 days for Level I, every 120 days for Level II, and every 30 days for Level III. A home visit may be indicated by case needs, as would be appropriate by client service level requirements.

Inter- or intra- agency case conferences should be held as case needs require. Case conferences may include any or all of the following:

Case manager(s)
Client(s)
Family members
Other health care providers
Medical, nursing, and social work staff
Social service department
Local child welfare agencies
Other community based organizations
Other service providers

Case conferences may be held weekly, semi-monthly, etc., but minimally must be held once each month with a permanent file verifying attendance (sign in sheet) and cases discussed.

STANDARD: Case Management Process
H. Reassessment

A periodic formal review and re-evaluation of the client/family's situation, functioning, clinical and psychosocial needs in collaboration with the client to identify changes which have occurred since the initial or most recent assessment is required for all clients within the case management system.

RATIONALE: Reassessment is a scheduled or circumstance-generated formal re-examination of the client's life situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. A formal reassessment is due within 30, 90, or 180 days of the completion of the original assessment: (a) depending on the stage of HIV disease and level of service, and (b) at the same periods thereafter or when a change in the client's status occurs which significantly affects the client's well being or the individualized service plan.

DISCUSSION: Significant changes in client/family status may include, but are not limited to:

- change in the client's clinical or functional status, (reduced capacity to perform activities of daily living);
- death, illness or hospitalization of a family member or care giver(s);
- a circumstance which impairs the client's ability to provide for his/her, or the family's physical and/or emotional needs;
- loss of housing, employment, child care; and
- other legal or economic crises.

Reassessments are the responsibility of the primary case manager, with assistance from others (including aides or staff of cooperating agencies). Reassessment information must be documented on forms developed or approved by the coordinating body.

During the formal reassessment, the case manager conducts a review with the client/family of each area of need identified in the initial assessment. Reassessment also includes clinical information on stage of HIV disease, medication regimens, other psychosocial complexities and appropriate information from all agencies involved with the client (a case conference must be held with these agencies, and may include the client/family and support persons). The reassessment will measure progress toward or barriers to the desired goals outlined in the individualized service plan.

(continued)

Updating the Individualized Service Plan (ISP)

This reassessment information is used to prepare in collaboration with the client an updated or revised ISP, or confirm that current services and plan remain appropriate.

An update of the service plan may also occur as a result of changes in clients' needs, or information from monitoring contacts when changes are not so significant as to require a formal reassessment. A new ISP must be completed should a major change in client status or clinical symptoms occur which would significantly affect the original service plan.

A copy of the updated ISP must be provided to the client.

STANDARD: Case Management Process
I. Crisis Intervention

Case management providers must have a crisis intervention plan in place, which identifies responsibility for services provided through referral or formal agreements with other internal or external programs.

RATIONALE: The purpose of crisis services is to provide assessment and referral for acute medical, social, physical or emotional distress. Crisis services may be needed for a variety of reasons, such as an emergency medical need, drug use, loss of housing, domestic violence or child abuse. Regardless of the nature of the crisis, it is the responsibility of the case manager or provider agency to assist the client or family in obtaining the appropriate response to the situation, keeping in mind the need to maintain the client's dignity and right to privacy and confidentiality. In addition, the crisis intervention should be designed to decrease inappropriate utilization of emergency services by targeting the response more appropriately to the identified crisis.

DISCUSSION: Crisis intervention planning must be a part of each individualized service plan (ISP). Clients must be instructed on how and when to identify the appropriate crisis response for a given emergency need. These responses should be discussed with the family and informal caregivers as well. The agency should take steps to assure that crisis services are utilized only when necessary, but that crisis services are available on a 24-hour basis. In addition, the provider agency must have a crisis plan or crisis manual that includes appropriate emergency responses.

All incidents requiring crisis intervention shall be documented in the client record and reported to the case manager. The case manager, in turn, will review the ISP to determine what revisions are necessary to assist the client, and review them with the client. Crisis intervention may be a joint responsibility of the case manager or other members of the case management team. Supervisory staff support and supervision must be available to case managers and/or the case management team involved in crisis intervention.

Crisis intervention, when used effectively, generally leads toward reduced client/family emotional stress. It may also help the client to overcome situations that are likely to be perceived as “out of control” and not anticipated in the ISP.

STANDARD: Case Management Process
J. Change In Service Level

Due to the HIV disease spectrum, disease management and available medications, service levels for clients may change dramatically at any given point in time. Therefore, allowances must be made to coordinate/provide care at a level appropriate to disease stage.

RATIONALE: A very important component of case management service planning is assisting the client in becoming proactive with regard to his/her health care, empowering clients to become independent to the fullest extent possible.

DISCUSSION: With the HIV disease process changing due to new medications, some are finding that it is possible for clients who were once receiving in-home supportive services to, at a point in time, return to work. When possible, the case management process should assist the client in becoming independent and case managers should support and encourage the client in his/her endeavors. It is also acknowledged that over time a client may no longer have the ability to continue working and/or remain independent. Because of this, the case management process must allow for changes in service levels at any give point in time. Changes in service levels must be implemented to increase independence, when appropriate, which will improve the client's quality of life and ability to cope with the disease process.

STANDARD: Case Management Process
K. Exit Planning/Case Termination

Each agency shall have a written plan, outlining the criteria for case discontinuation and exit planning. Clients/families shall be informed of these criteria at the time of intake and assessment, and shall be involved, if possible, at the time of termination.

RATIONALE: Every case management situation will reach a point where services are no longer required for a variety of circumstances. Exit planning/case termination procedures are initiated when the client:

expires;
is no longer eligible due to loss of programmatic eligibility;
declines the case management services;
is capable of coordinating their own case management needs or is desired by the client;
will be institutionalized for greater than 30 days and discharge to community- based care is not anticipated;
relocates out of the provider's service area;
cannot be located or does not become involved in service planning within six months of application for services; or
refused to sign or abide by behavior contract agreement.

DISCUSSION: Discontinuation of services/exit planning is the responsibility of the case manager with assistance from the members of the case management team. A summary noting case disposition and measures of progress toward identified goals must be prepared and placed in the final record. Other cooperating service providers should be notified of the case disposition, within parameters of allowable disclosure per statute and regulations.

In all cases, except where the client expires, or refuses to become involved in planning, the provider must attempt to complete a referral to link the client with other appropriate ongoing case management and vital services necessary to meet his/her care needs. Upon client's request, a case summary must be prepared for referral to the new provider.

STANDARD: Case Management Process
L. Documentation

All agencies providing case management services will have a system of documentation which includes an integrated set of common data elements utilizing forms approved by the coordinating body. It will also be the standard for all agencies to collect and monitor data through the use of a common database system. All records will be handled, sorted and maintained in a secure and confidential manner.

RATIONALE: Documentation refers to the process of recording, storing and transferring information regarding the client/family, their care and the case management process itself. This documentation serves to:

communicate client assessment and service planning and implementation information to core case management team members;
meet legal record keeping requirements for case management;
substantiate care decisions made with or on behalf of the client;
collect data necessary for client care and program decisions;
allow an assessment of the cost effectiveness and appropriateness of funded services;
document the activities of case management and related activities in a uniform, comprehensible manner; and
document client eligibility for services.

DISCUSSION: All funded agencies will have the following documentation for each client receiving services as required by each level of service:

#	face sheet: demographic data including emergency contacts, legal representatives, intake information, and necessary updates.	Level I, II, and III
#	insurance benefits record: policy and/or eligibility verification (if applicable).	Level I, II, and III
#	physician certification of HIV disease	Level I, II, and III

(continued)

#	client (or legal representative) signed consent for program participation, release of information, client's rights in case management, fair hearing rights for denial/discontinuation of services, and applicable grievance procedures.	Level I, II, and III
#	initial comprehensive assessment within fifteen (15) days of enrollment.	Level I, II, and III
#	re-assessments for clients at Level I must occur at a minimum of every 180 days.	Level I
#	re-assessments for clients at Level II must occur at a minimum every 90 days.	Level II
#	re-assessments for clients at Level III case management must occur at a minimum of every 30 days.	Level III
#	individualized service plan: initial plan, monitoring documents, and reassessment documents must be placed in client file within five (5) days.	Level I, II, and III

(continued)

#	Client records must contain at minimum: ❖ Report of all client interactions; ❖ Identify any current physical, psycho-social, and functional status changes; ❖ New problems identified with planned interventions noted; ❖ Education, counseling, referrals, or other direct services provided to the client; ❖ Any phone contact or face-to-face contact with client, caregiver, service provider(s), physicians, etc.; ❖ Summary/notation of monthly case conference when special cases for levels I and II are presented and for all level III cases of record; ❖ Copies of appropriate correspondence, medical and provider service records (as applicable based on level of service); ❖ Demographic data collection form, including initial enrollment and recording of initial services provided with update summaries when services are decreased or increased with explanation of reason for changes; and ❖ Documentation of the client's (or representative's) input into the individualized service plan and the identified services provided through the case management program(s).	Level I, II, and III

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Riverside/San Bernardino, California EMA
Case Management Standards

All funded agencies will handle, store, and maintain all records in a confidential and secure manner.

To accomplish this standard:

All documents must be secured in the record and protected from potential damage.

No forms shall be destroyed or removed from the records once entered into them.

Records shall be available only to the agency staff directly responsible for filing, charting, and reviewing, and to state and federal or local representatives as required by law.

Transfer of documents between cooperating agencies must be accomplished in a manner to protect the security and confidentiality of the materials.

Client records must be protected from unauthorized access, computerized records must have appropriate safeguards, and client records must be kept in a locked storage area.

Provider agency policy must address the manner and length of time the documents will be stored, as well as removal from storage and destruction of records. A plan must be specified for record storage and retrieval if the organization were to cease operations (as specified by current state law).

Medical/health care information cannot be released verbally, in writing, or copied from records without a written consent for the release of information signed by the client (or legally authorized representative). This consent must specify the type of information to be released and to whom, and may be revoked at any time by the client (or legally authorized representative).

The provider agency shall have written policies addressing the circumstances and processes by which all or part of a record may be released and to whom. Original documentation may be released only when required by court subpoena, otherwise photocopies should be provided.

Current state law will be followed regarding client access to records.

STANDARD: Client Rights and Client Advocacy

Agency policies and procedures shall be in place that ensure and protect client rights and provide for staff advocacy on behalf of clients. Case management staff shall be trained in these policies and shall ensure that client rights are protected in all aspects of the program.

RATIONALE: A major function of the case manager is to be an advocate for services for the client with particular emphasis on self-sufficiency in the community and avoidance of premature or unnecessary hospitalization. A percentage of time spent by the case manager can be expected to be related to non-client specific activities such as interagency coordination for the purpose of developing needed, non-existent resources in the community, reorganizing access to existing services, and developing referral agreements and relationships between existing agencies as specified in the section on case management process. Case managers may also participate in the development of the continuum of care and in community efforts to bring attention to the problems associated with the lack of services.

DISCUSSION: In the context of the aforementioned case management activities, clients' rights must always be observed and protected, and every effort made to safeguard the individual's rights. The following are mandatory criteria:

All case management staff shall be trained on the rights of clients and on confidentiality.
The case management agency shall have written policies and procedures regarding the rights and responsibilities of clients, including grievance procedures for clients.
Case management staff must exhibit sensitivity toward the family unit (as defined in these standards), recognizing that the family may be a constant in the client's life, while service systems and personnel fluctuate.
Each client or authorized client representative shall be informed of his or her rights in writing, at the time of admission into the program through the execution of a signed client consent form. This includes the client's right to:

    ❖ collaborate in the development and revision of the individualized service plan and of the exit plan, and be informed of the scope and limits of all services to be provided, including when and how and by whom such services will be provided;

(continued)

- be given the name, agency address, agency telephone number, and function of any person and affiliated agencies providing care or services to the client;
- decline any portion of the plan after being fully informed of and understanding the consequences of not receiving such services;
- recommend changes in policies and services to program staff, local agency staff and to county or state agency staff;
- voice complaints and to seek protection from mental, physical and financial abuse, mistreatment and neglect;
- be informed both verbally and in writing of available grievance procedures;
- be informed of the conditions under which he or she may be discharged;
- be treated with respect, consideration, and full recognition of his or her dignity and individuality;
- be shown proper and current identification by any person providing services in the home and to have his or her wishes regarding the home environment, furnishings and possessions respected;
- have his or her case records treated confidentially;
- receive a copy of, and review, case records in accordance with state law, and
- receive services without regard to age, race/ethnicity, creed, color, gender, sexual orientation, marital status, political affiliation, disability status, or other protected class.

STANDARD: Provider Qualifications
General

All case management provider agencies shall demonstrate capacity to meet certain organizational, structural and administrative qualifications.

RATIONALE: To ensure that all agencies provide high quality, consistent delivery of services in a cost effective manner. A case management provider agency for the purposes of these standards shall include: a nonprofit social services agency, facility, organization, department, office, corporation, partnership, group, or individual funded to provide targeted case management services for HIV infected persons.

DISCUSSION: Agencies funded to provide HIV/AIDS case management services shall:

Clearly define the target HIV population they intend to serve and the scope of their services. Definition must be inclusive of family members and/or significant members of client's support system.

Demonstrate client participation in policy making roles within the organizational structure.

Possess adequate capacity to address the needs of the population they purport to serve.

Possess and maintain adequate insurance consistent with contract guidelines and valid licensing if applicable.

Maintain administrative functions that demonstrate an ability to sustain services without disruption and support the delivery of high quality, culturally sensitive, client-centered case management in a cost effective manner.

Strive to utilize diverse public and private funding opportunities or funded service programs that strengthen the agency's financial base. Funding resources and the agency's fiscal contingency plan are adequate to ensure continuity and level of case management services to the client.

Promote the development of resources and care coordination using an interdisciplinary team approach whenever achievable and appropriate.

Make every effort to develop strategies and build infrastructure to reimburse rendered services through third party payers, public insurance or managed care contracts.

(continued)

Riverside/San Bernardino, California EMA
Case Management Standards

Maintain client records that meet state and federal requirements and provide information to verify compliance.

Maintain a safe and secure physical environment which complies with all federal, state, and local laws and regulations (including the Americans with Disabilities Act) and furnish services without discrimination.

Maintain a manual for policies and procedures which includes all policies and procedures relevant to general operations, service delivery, personnel requirements, client records, and data security.

Store electronic and paper records in a secure manner that meets with state and federal guidelines for confidentiality.

Ensure that quality assurance and utilization review processes are carried out with client participation and according to the agency's quality assurance guidelines.

Maintain written agreements regarding inter-agency and intra-agency working relationships that support the implementation of case management.

Maintain a client information management system that is consistent with these standards.

Designate a project director to provide oversight of case management services.

Employ professional technical and support staff, qualified by education and experience, to carry out the requirements of the contract and case management standards.

Maintain a plan for staff and volunteer orientation, training, ongoing education, and supervision.

Maintain a protocol and procedure for tracking and responding to grievances, and include clients in appropriate roles to address grievances.

Maintain and further develop linkages to a broad spectrum of service entities providing services necessary for access by clients, and actively collaborate with other case management and service coordination programs in the community.

Regularly participate in the Ryan White CARE Act Title I Inland Empire HIV Planning Council functions with a focus on needs assessment, comprehensive planning, and priority setting.

STANDARD: Provider Qualifications
Interagency Collaboration and Service Coordination

All agencies providing HIV/AIDS case management services in the Riverside/San Bernardino, California EMA shall develop effective methods of interagency collaboration and service coordination. These shall be implemented through appropriate written agreements, contracts or memoranda of understanding.

RATIONALE: The goal of interagency coordination, collaboration and referral agreements is to reduce gaps in service for people living with HIV, increase the quality of care for patients and to maximize the effectiveness of funding allocated for case management services.

DISCUSSION: Coordination will be accomplished through case conferences among agencies that have clients who receive complementary services from each. Each agency will have a written procedure in place to ensure that clients who receive services from more than one agency have received mutually agreed upon services based on the individualized service plan (ISP). To increase the effective coordination of client care, it is anticipated that a common database and common forms will be developed within the EMA. All funded agencies will utilize this system once it is developed. Additionally, agencies are required to secure from clients a signed consent to release information to referral agencies involved in the client's case management plan. This will allow agencies to discuss a shared client's need to ensure that all needs are identified and met.

Collaboration will be accomplished by agency representation on HIV planning groups. This includes, but is not limited to, the Inland Empire HIV Planning Council and any other *ad hoc* or task force committees focusing on case management issues. Funded agencies will be expected to collaborate with the coordinating body. It is anticipated that as the HIV disease changes, so will the case management needs of those affected by HIV. Funded agencies located in the same geographic region will be required to collaborate and coordinate services offered in a given area to reduce duplication.

To reduce the gaps in service for people living with HIV, as well as reduce duplication, agencies may need to refer clients to other area agencies that provide those needed services. It is the responsibility of each agency to develop interagency referral procedures.

Written agreements or contracts will be developed between provider agencies specifying services available, client eligibility criteria, and procedures for referral, monitoring and follow-up, and feedback to the referring agency. Mechanisms must be developed to ensure that problems identified on shared cases will be discussed in a timely manner between agencies.

(continued)

Inter-agency referrals will include, at a minimum, the following information:

specific services required by the client/family;
unique issues affecting the provision of services;
expected outcome(s);
health insurance or other financial resources, if available;
other pertinent information; and
estimated service completion date, if applicable.

In order to implement an anonymous process to prevent duplication of case management services, the following protocol will be followed by provider agencies (subject to modification by the coordinating body and approved by the Inland Empire HIV Planning Council):

On a monthly basis, each funded case management agency will provide a Management Information Systems printout of unique identifiers and date of enrollment to the AIDS program manager in San Bernardino County;

The AIDS program manager will cross reference each case management agency's list and note unique identifiers that are duplicated between providers;

The AIDS program manager will provide each case management agency with a list of those unique identifiers that appear on another providers list;

For unique identifiers that are duplicated, each case management agency will send a standard letter (a sample of which appears below) on agency letterhead with a self addressed postage paid envelope informing the client of the non-duplication policy and asking him/her to choose the agency he/she would prefer for case management services;

Based upon the client's instructions, the case management entity will either maintain enrollment or inactivate the client;

If the client has not responded within 60 calendar days (and continues to appear on multiple agency unique identifier lists), the AIDS program manager will instruct the agency with the most recent enrollment date to disenroll the client; and

This case management entity will disenroll the client and send them a standard notice of action letter (sample follows).

(continued)

This procedure does not prohibit the client from changing case management providers as individual circumstances and preferences change. However, it is the expectation of the Inland Empire HIV Planning Council that clients limit transfers between provider agencies to a maximum of two times in a twelve month period.

Agency Letter Head

We have been informed by a process (which does not utilize names, but other coded information) utilized by the Inland Empire HIV Planning Council, that you are receiving HIV/AIDS case management services from more than one agency. It is the policy of the Inland Empire HIV Planning Council which funds and oversees these services that only one case management agency should be utilized at a time.

You are free to chose which provider you would prefer. Please indicate below whether you wish to continue receiving case management services from us or would like to be disenrolled. You will also receive the identical letter from any other agency(ies) that is(are) also providing you with case management services. Please provide each agency with your instructions.

You may change your enrollment at a later date, but the Inland Empire HIV Planning Council expects that transfers between provider agencies be limited to a maximum of two times in a twelve-month period.

If we do not hear from you within 60 calendar days, you will automatically be disenrolled from the case management service program in which you most recently enrolled.

If you have any questions you may contact _____ at _____.

Thank you for assisting us!

Sincerely,

Agency Representative

Name of Client:

☐ Maintain my case management enrollment ☐ Disenroll me from case management

(continued)

Notice of Action
Agency Letter Head

Date:

Dear (Client):

This letter serves to inform you that we have disenrolled you from case management services and inactivated your client file with us for the following reasons:

☐ You have requested us to disenroll you;

☐ Lack of proof of HIV status (proof of HIV infection must be established to qualify for services);

☐ You have duplicate enrollment; you are now enrolled with an alternate provider;

☐ We do not provide the level of case management services you require, you have been transferred to_____;

☐ You have moved outside our service area;

☐ Other _____.

If circumstances change, please feel free to contact us about re-enrollment. If you believe we have taken this action in error or have any questions regarding this notice of action, please feel free to contact _____ at _____.

Sincerely,

Case management representative

cc: client file

STANDARD: Provider Qualifications
Resource Directory and/or Client Handbook

Each case management agency shall procure and maintain available directories of : health and social service programs, entitlement programs, educational programs, legal services, spiritual and social support programs to which clients may be referred, consistent with their needs as reflected in the individualized service plan (ISP). Agencies shall attempt to secure eligibility and referral information for use by case management personnel and clients.

RATIONALE: A long term goal of the Planning Council is to develop a comprehensive directory of available services in the EMA and surrounding communities. This will assist staff and clients to develop the optimum ISP as applicable for each person receiving case management services. The information will assist in effecting appropriate and timely referrals for needed on-going and emergency services.

DISCUSSION: This resource directory may be developed by each agency, or collaboratively between and among EMA funded case management agencies. The types of agencies, services and programs that should be included in this directory, at a minimum, are:

Health services (in-patient, ambulatory clinics, private providers)
Mental health services
Home care services
Health practitioners
Dental care
Alternative health services
Medication subsidy programs (ADAP, etc.)
Medi-Cal
Private health insurers
Managed care programs and HMOs
Rehabilitation services
Drug and alcohol treatment programs
Social services
Housing programs (HOPWA, HUD, etc.)
Food banks
Day care
Maternal and child health programs

(continued)

Family planning services
Legal services
Job training
HIV/AIDS support groups
Spiritual/religious services
Educational opportunities
Transportation assistance programs

As a public document, this directory (or specific entries therein) should be available to clients/families upon request. Staff must offer the client/family assistance in understanding and interpreting the directory entries and their potential usefulness as appropriate service resources.

Riverside/San Bernardino, California EMA
Case Management Standards

STANDARD: Staff Qualifications

Each agency shall have defined qualifications for professional and technical staff employed to provide case management services.

RATIONALE: The provision of quality, effective and appropriate HIV/AIDS case management services requires a range of knowledge, professional and technical skills, and practice competencies. Emotional health and maturity are vital personal characteristics for staff who must work daily with chronic and acute illness, death and loss, and disruption of client and family lives. The following are qualifications that are presented as required minimum qualifications when hiring staff to work in case management programs which adhere to these standards. *(The Inland Empire HIV Planning Council approved the Case Management Standards on August 27, 1998.*)

Case Manager (Level I): Must have either a working background in HIV/AIDS case management, educational background in health and human services field, or other workplace or educational training that would be relevant to the position. One of the following is preferred (with documented case management experience): Bachelor of Science (BS) degree, or Bachelor of Arts (BA) degree. Candidate must demonstrate:

- ❖ Effective written/verbal communication skills
- ❖ Interview assessment skills
- ❖ Superior interpersonal skills
- ❖ Ability to identify and resolve problems
- ❖ Knowledge of available community services and qualification requirements
- ❖ Understanding of and ability to provide intervention
- ❖ Ability to implement and maintain working relationships with all available community resources
- ❖ Emotional and mental maturity
- ❖ Cultural sensitivity
- ❖ Ability to interact with other professionals
- ❖ Knows how to document and understands importance of documentation flow and continuity
- ❖ Understanding of HIV disease spectrum/treatment options
- ❖ Awareness of the benefits procurement spectrum to ensure appropriate referral
- ❖ Ability to provide instruction in financial planning
- ❖ Ability to procure additional community services not previously utilized
- ❖ ATS certification within 12 months of hire and/or other approved skills training as may be approved by individual agencies
- ❖ Fluency in local Language

Case Manager (Level II): BS/BA Degree with documented experience in medical or social case management and/or a registered nurse licensed to practice in California. Must have background/knowledge and capabilities to perform comprehensive assessments, full understanding of coordination, monitoring, and evaluation.

(continued)

Riverside/San Bernardino, California EMA
Case Management Standards

Candidate must demonstrate proficiency of skills typically found in a bachelor's degree prepared individual, including:

- ❖ Knowledge of HIV disease spectrum and clinical guidelines
- ❖ Effective written/verbal communication
- ❖ Interview/assessment/interpersonal skills
- ❖ Ability to identify and resolve problems
- ❖ Crisis intervention skills
- ❖ Understands and can work with a variety of organizations
- ❖ Emotional and mental maturity
- ❖ Cultural sensitivity
- ❖ Interact with other professionals
- ❖ Fluency in local language
- ❖ Knows how to document and analyze data
- ❖ Budget/management skills
- ❖ One or more years case management experience
- ❖ ATS certification is desirable within 12 months of hire, regardless of qualifications
- ❖ Understand and be able to provide comprehensive benefits counseling and financial management planning

Case Manager (Level III): Registered Nurse with either two years community experience, public health experience and/or one year community and clinical experience. A Bachelor of Science degree in Nursing (BSN) and/or Registered Nurse with Public Health Nurse (PHN) certification are highly desirable. Knowledge and/or experience in the field of HIV/AIDS desirable.

Social Worker with either a Master's degree in Social Work (MSW), Master's degree in Family Counseling (MFCC), a Licensed Clinical Social Worker (LCSW), Master's degree in Psychology (MMA), or comparable degree. Both registered nurse (RN) and master's level social worker must have background/knowledge and capabilities to perform comprehensive assessments, as well as a full understanding of coordination, monitoring, and evaluation. Case management certification is a plus. Must have an understanding of the RN/SW team model and demonstrate proficiency skills as follows:

- ❖ Knowledge of HIV/AIDS disease spectrum and clinical guidelines
- ❖ Effective written/verbal communication
- ❖ Interview/assessment/interpersonal skills
- ❖ Ability to identify and resolve problems
- ❖ Crisis intervention skills
- ❖ Understands and can work with a variety of organizations
- ❖ Emotional and mental maturity
- ❖ Cultural sensitivity
- ❖ Interact with other professionals
- ❖ Fluency in local language
- ❖ Knows how to document and analyze data
- ❖ Budget/management skills
- ❖ One or more years case management experience
- ❖ ATS certification is desirable within 12 months of hire, regardless or qualifications
- ❖ Understand and be able to provide comprehensive benefits counseling and financial management planning

Proof of qualifications must be present in all applicable personnel files. All staff positions will need to meet minimum qualifications within two years from the date case management standards were approved for implementation.

Riverside/San Bernardino, California EMA
Case Management Standards

STANDARD: Supervision

Each agency shall provide appropriate levels of supervision to all paid and volunteer staff providing case management services.

RATIONALE: To ensure that the services are: consistent with the agency policies and mission statement, appropriate, relevant, delivered in a timely manner, and consistent with the individualized service plan. To assist in staff professional development of knowledge, skills, and understanding of effective case management principles and procedures as they pertain to HIV/AIDS service delivery.

DISCUSSION: Supervision is an important component of the continuous quality improvement program of each agency. The agency shall demonstrate a system to provide staff supervision that shall be within the scope of professional practice. Supervisors must possess professional qualifications as defined by the standards of their profession. Supervision is included in, but not limited to:

- ❖ Review of case documentation
- ❖ Review of progress notes
- ❖ Review for use of integrating referrals
- ❖ Assessment of a relevant individualized service plan to identify problem areas and needs
- ❖ Review and assessment of the adequacy of each documented phase of the case management process
- ❖ Individual supervision
- ❖ Group supervision
- ❖ Peer supervision
- ❖ Case conferences, both internal and external to the agency
- ❖ Chart review, both scheduled and random
- ❖ Review of client grievances

There shall be an annual performance review by the supervisor provided in writing with the opportunity for staff response and acknowledgment of the review.
Establish a feedback mechanism that would include a link between the agency's continuous quality assurance entities, the supervisor and the appropriate staff.
Identify the gaps in services and the barriers to providing or accessing services.
Provide documentation of on-going supervision and have documentation available for review.
Each agency shall develop job descriptions with appropriate education and experience requirements for the person providing supervision.
A system must be in place to provide immediate crisis and internal on-going supervision.

Riverside/San Bernardino, California EMA
Case Management Standards

STANDARD: Training

Each funded agency shall provide staff orientation, staff development and in-service training to all levels of case management personnel. Retraining shall be required for staff on matters relevant to the conduct of case management which experience significant change over time.

RATIONALE: To ensure that all staff have the required skills to provide quality client focused case management services consistent with the EMA case management program standards.

DISCUSSION: Staff development and training may be provided within each agency, through the cooperative efforts of two or more agencies, or through an area-wide program sponsored by the collaborating agencies and the Inland Empire HIV Planning Council. Important aspects of a training program are:

Updated HIV information will be centralized and readily available to staff.
Knowledge of community resources and services will be assessed and updated at least annually.
Training to include, but not be limited to the following areas:
    - ❖ AIDS 101 (basic transmission and protection information)
    - ❖ Sex and relationship information
    - ❖ Safer sex information
    - ❖ ATS training
    - ❖ Medications: monitoring, adherence, and complications
    - ❖ Recommended additional training areas include:
        - Complimentary therapies
        - Death and dying
        - Risk reduction
Develop annual goals and objectives for professional growth identified by the staff and supervision.
Develop training for understanding of entitlement programs and processes for accessing benefits.
Develop ongoing training on diversity and cultural competence issues.
Encourage professional staff development and/or educational advancement.
Develop a plan for continuous in-service training.
Provide for on-going awareness of cultural diversity issues.
Develop a plan for maintaining the continuous awareness of confidentiality and issues of staff boundaries.
Evidence of participation in education and training shall be included in personnel records.

Riverside/San Bernardino, California EMA
Case Management Standards

STANDARD: Agency Monitoring and Program Evaluation

Each case management agency in the EMA shall implement the case management standards developed and approved by the Planning Council. In collaboration with the grantee, each provider shall participate in the EMA contracted programmatic monitoring and continuing Quality Improvement (CQI) process to insure the quality of implementation of these standards. These programmatic monitoring and CQI process to insure the quality of implementation of these standards. These programmatic monitoring and CQI activities will utilize the expertise of grantee, provider staff, and consumers in developing the processes to carry out these activities.

RATIONALE: Through the mutually beneficial relationship established and built upon, grantee staff will work collaboratively with agency and supervisory case management staff to implement the programmatic and contractual monitoring as required by HRSA. Adequate and appropriate case management supervision assures that the agency is in compliance with the EMA case management standards and other requirements and criteria. This supervision provides the opportunity for each agency to validate its infrastructure, services and operations and to develop a plan of correction for any problems identified. Case Management supervision is an internal monitoring process that includes, but is not limited to yearly chart reviews utilizing approved chart review indicators, yearly client satisfaction surveys (those which allow for anonymity and are approved for release), yearly review of data collection efficiency, staff productivity, and others.

Beginning 2001, one of HRSA's highlighted and required elements is the system-wide implementation of Continuous Quality Improvement. This CQI process affords the Inland Empire HIV Planning Council an opportunity to review the EMA-wide case management system and each participating agency for quality and efficiency. It enables a review of each agency's capabilities and ability for compliance with case management system requirements, fiscal requirements and provides recommendations for improvement in areas where improvements are required. The CQI process will be coordinated with the programmatic and fiscal monitoring performed by the grantee and qualified persons knowledgeable of care management protocols and CQI practices. No individual affiliated with or employed by an agency that receives or may receive funds for case management services should be on a review committee for that particular agency.

DISCUSSION: The CQI outcomes will be gathered for analysis by the grantee. These case management standards establish the framework for the quality delivery of services. A summary of the overall EMA CQI finding's, without specific provider identity, will be submitted to the Planning and Evaluation Committee of the Inland Empire HIV Planning Council for input and further recommendation. To the extent possible, programmatic and fiscal technical assistance will be provided to enhance the quality of service.

Riverside/San Bernardino, California EMA
Case Management Standards

(Insert EMA-wide evaluation instrument here)

Riverside/San Bernardino, California EMA
Case Management Standards

Resources Utilized:

AIDS Atlanta Case Management Program

AIDS Foundation of Chicago

A Primary Care Guide to HIV Disease
Scott Eberle, MD, Marshall Kubota, MD

California Ryan White Consortia, HIV Case Management-Care/Service Coordination, Standards of Care & Practice, Task Force Recommendations, December 1996

Case Management Algorithm
Lawrence Shulman

CCM Certification Guide
Commission for Case Manager Certification

New York State Department of Health/AIDS Institute Case Management Guidelines

Pan American Health Organization/Sociomedical Resource Associates, Inc, Working Conference, HIV/AIDS Case Management, August 1991.

Standards of Care and Practice, Ryan White Task Force - Working Draft

State of California Department of Health Services/Office of AIDS

State of Florida, Department of Health & Rehabilitation Services, Case Management Standards

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(To Be Developed)